IMPACT OF MANAGED CARE ON THE LEVEL OF SPENDING

This section revises CBO's previous estimates of the potential savings from moving people into more effective forms of managed care.[27] As in the August 1992 analysis, it presents illustrative estimates of the change in the level of health spending that might result if all insured acute services for health care were provided through delivery systems incorporating one or both of two specific forms of managed care: effective HMOs, which could include group/staff HMOs or tightly managed IPAs; and effective utilization review, which would include precertification and concurrent review of inpatient care. The analysis assumes that savings would reflect the expected change in use of services as people moved to more effective forms of managed care.

Estimates of the current distribution of people among managed care plans are unchanged from the previous CBO analysis, as are the assumptions about the average effects of managed care in the fee-for-service sector.[28] Assumptions about the effects of group/staff HMOs and IPAs are different, however: the average effects of group/staff HMOs are smaller, and the average effects of IPAs as a group are larger (see Table 4). The new assumptions about HMOs and IPAs relative to unmanaged care are derived from Lewin-VHI estimates for

27. See Congressional Budget Office, "The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures" (August 1992).

28. CBO made two alternative sets of assumptions in its previous analysis. In this memorandum, only the first set of assumptions is used for illustrative purposes.

TABLE 4. AVERAGE PERCENTAGE REDUCTIONS IN USE ASSUMED FOR PEOPLE IN MANAGED CARE PLANS COMPARED WITH THOSE IN UNMANAGED FEE-FOR-SERVICE PLANS

Primary Source of Insurance Coverage	Percentage Reduction in Use of Services by Type of Managed Care[a]				
	I	II	III	IV	V
Average Reductions Assumed in CBO's Current Analysis					
Medicare	11.6	3.2	4.0	2.0	0
Medicaid	5.8	1.6	2.0	1.0	0
Private or Other Public	11.6	3.2	4.0	2.0	0
No Insurance	0	0	0	0	0
Average Reductions Assumed in CBO's 1992 Analysis[b]					
Medicare	15.0	2.0	4.0	2.0	0
Medicaid	7.5	1.0	2.0	1.0	0
Private or Other Public	15.0	2.0	4.0	2.0	0
No Insurance	0	0	0	0	0

SOURCE: Congressional Budget Office.

NOTES: The analysis assumes that changes in use result in comparable changes in cost. The effect of managed care on use of services for Medicaid enrollees is half the reduction assumed for enrollees in Medicare and private insurance plans, reflecting the expectation that payment rates and access to services for Medicaid enrollees would increase under managed care arrangements. Uninsured people are unaffected because managed care programs are put in place by insurers. The reduction in use assumed for independent practice associations (category II) is less than that assumed for effective utilization review (category III), even though most IPAs have utilization review programs in place, because IPAs typically have lower cost-sharing requirements than conventional FFS plans.

a. Categories of managed care are defined as follows:
   I. Group/staff health maintenance organizations;
   II. Independent practice associations (including network models);
   III. Utilization review including precertification and concurrent review of inpatient hospital care,
   IV. Other forms of managed care (including preferred provider organizations);
   V. No managed care.

b. Under Alternative 1 in Congressional Budget Office, "The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures," CBO Staff Memorandum (August 1992).

HMOs and IPAs relative to fee-for-service care, together with the average assumed effects of managed care in the fee-for-service sector.[29]

If all insured people were in effective HMOs, potentially manageable personal health expenditures would be 7.7 percent lower, using assumptions developed in the preceding assessment of research (see Table 5).[30] All personal health expenditures would be lower by 6.3 percent, and national health expenditures would be lower by 5.5 percent (see Table 6). Enrolling all insured people in effective HMOs, however, would require more than a fivefold expansion of current HMO capacity; it would also require significant changes in management for many IPAs. Further, at least 30 percent of the population resides in less populated areas of the country that might not support the HMO approach.[31]

If, instead, all insured people in less effective forms of managed care were moved into effective utilization review programs and the proportion of insured people in the most effective HMOs was unchanged (at about 6 percent),

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29. The average effect of managed care in the fee-for-service sector is to reduce use by 2.8 percent compared with unmanaged care. The Lewin-VHI estimate is that group/staff HMOs reduce use by 9.1 percent relative to the current fee-for-service sector, and thus by 11.6 percent relative to unmanaged care [(1-0.091)*(1-0.028) = 0.884].

30. Potentially manageable spending is that portion of health care spending that managed care could affect--generally, those personal health services that are typically offered as insurance benefits. CBO estimates that about 71 percent of national health expenditures are potentially manageable.

31. R. Kronick and others, "The Marketplace in Health Care Reform," *The New England Journal of Medicine*, vol. 328, no. 2 (January 14, 1993).

TABLE 5. ESTIMATED SAVINGS IN 1990 EXPENDITURES AS A PROPORTION OF POTENTIALLY MANAGEABLE EXPENDITURES (In percent)

Primary Source of Insurance Coverage	Type of Managed Care for the Insured Population: All in Effective HMOs	6 Percent in Effective HMOs and 94 Percent in Effective Utilization Review	70 Percent in Effective HMOs and 30 Percent in Effective Utilization Review
All Sources	7.7[a]	1.3[b]	5.7[c]
Medicare	9.3	1.9	7.0
Medicaid	5.6	1.9	4.5
Private or Other Public	8.2	1.1	5.9
No Insurance	0	0	0

SOURCE: Congressional Budget Office. The comparable estimates given below are from Congressional Budget Office, "The Potential Impact of Certain Forms of Managed Care on Health Care Expenditures," CBO Staff Memorandum (August 1992), Table 5, Alternative 1.

NOTES: Potentially manageable expenditures are the portion of health care spending that managed care could affect, which includes all personal health services that are typically offered as insurance benefits. Effective health maintenance organizations (HMOs), which may be group/staff HMOs or tightly managed independent practice associations, are assumed to reduce use of services (compared with unmanaged care) by the percentages shown for Category I in Table 4. Effective utilization review, which would include precertification and concurrent review for hospital inpatient stays, is assumed to reduce use of services by the percentages shown for Category III in Table 4.

a. The comparable estimate from the previous analysis was 10.8 percent.

b. The comparable estimate from the previous analysis was 1.4 percent.

c. No comparable estimate was shown in the previous analysis.

TABLE 6. ESTIMATED SAVINGS IN 1990 EXPENDITURES AS A PROPORTION OF ALTERNATIVE HEALTH EXPENDITURE TOTALS (In percent)

Type of Expenditure	Type of Managed Care for the Insured Population: All in Effective HMOs	6 Percent in Effective HMOs and 94 Percent in Effective Utilization Review	70 Percent in Effective HMOs and 30 Percent in Effective Utilization Review
Manageable Personal Health Care Expenditures[a]	7.7	1.3	5.7
All Personal Health Care Expenditures	6.3	1.0	4.6
National Health Expenditures	5.5	0.9	4.0

SOURCE: Congressional Budget Office.

NOTES: Effective health maintenance organizations (HMOs), which may be group/staff HMOs or tightly managed independent practice associations, are assumed to reduce use of services (compared with unmanaged care) by the percentages shown for Category I in Table 4. Effective utilization review, which would include precertification and concurrent review for hospital inpatient stays, is assumed to reduce use of services by the percentages shown for Category III in Table 4.

a. The portion of health care spending that managed care could affect, which includes all personal health services that are typically offered as insurance benefits.

national health expenditures would be lower by 0.9 percent under the assumptions used here (see Table 6). Finally, if the 70 percent of the population residing in areas populous enough to support them were enrolled in effective HMOs, and effective utilization programs were put in place for all other insured people, national health expenditures would be lower by 4.0 percent.

IMPACT OF MANAGED CARE ON THE RATE OF GROWTH IN SPENDING

Although managed care programs reduce the level of health care costs compared with unmanaged care, there is no convincing evidence that they also reduce the rate at which costs subsequently increase. Studies attempting to show that some forms of managed care have reduced the rate of growth in costs compared with unmanaged care or with other types of managed care have typically relied on historical comparisons of growth rates in insurance premiums by type of health plan. Indeed, survey data collected from employers from 1988 through 1993 and reported by KPMG Peat Marwick show that the average annual rate of growth in employment-based premiums (using individual rates) was 10.1 percent for HMOs, 13.9 percent for PPOs, and 15.3 percent for conventional fee-for-service health plans.[32]

32. J. Gabel and D. Liston, "Trends in Health Insurance: HMOs Experience Lower Rates of Increase Than Other Plans" (KPMG Peat Marwick, Washington, D.C., December 1993), Exhibit 1.

But evidence based on rates of growth in premiums is too weak to support any conclusion about relative rates of growth in costs among types of plans. A valid comparison of costs among plans must look at total costs, including patients' out-of-pocket costs for services that are typically covered. Further, a valid comparison across plans must control for differences or changes in the demographic composition of enrollment.

The evidence does not support the conclusion that the rate of growth of total costs for HMOs is below that for FFS plans once provisions for benefits and cost sharing are standardized. Survey data from employers show that changes have been made in covered benefits and cost-sharing provisions since 1988 that would tend to reduce HMO premiums (or slow their rate of growth) and increase FFS premiums (or increase their rate of growth). For HMOs, covered services have been reduced, and the proportion of HMO enrollees in plans with no cost-sharing requirements has dropped from 62 percent to 20 percent.[33] For FFS plans, covered services have increased and coinsurance requirements have decreased.[34] Thus, the slower observed rate of growth of HMO premiums compared with that of FFS premiums from 1988 through 1993 is partly if not entirely explained by the decline in generosity of HMO plans

33. Ibid., Exhibits 4 and 8.

34. Ibid., Exhibits 4 and 7.

compared with FFS plans, not by an increase in the effectiveness with which HMOs control total costs.

However, a focus on whether or not managed care reduces the rate at which health care costs grow beyond its initial effect on the level of costs is probably misplaced, because the two effects are impossible to distinguish empirically when insurers are continually adopting new elements of managed care. A more appropriate focus would be whether or not managed care now delivers all of the cost savings that it could potentially yield.

Proponents of managed competition believe that potential savings from managed care are larger than those observed and that more of those potential savings would be realized under a restructured system that induced insurers to compete on the basis of price and quality. According to this reasoning, HMOs and other managed plans are less aggressive in limiting unnecessary care than they would be in a market in which consumers faced stronger financial incentives to choose more efficient insurance arrangements.

Under a restructured system, widespread managed care might more consistently eliminate unnecessary or ineffective care. It might also facilitate greater control over the adoption of cost-increasing technology and encourage the development of cost-reducing alternatives. But it is also possible that

savings per enrollee from any given type of managed care would fall if managed care was more widespread, because the new participants' commitment to the approach might be lower than that of current participants.

APPENDIX: DEFINITION OF TERMS RELATED TO MANAGED CARE

bonuses, related to performance: Incentives to provide only appropriate and cost-effective care to patients. Bonuses are sometimes offered to providers by managed care organizations in addition to their regular payment.

capitation: A form of payment that provides a predetermined amount per enrollee treated by the provider for a specified period of time. The provider agrees to accept this payment without regard to the type or frequency of services actually rendered.

case management: Involves coordinating and planning services for high-risk cases or high-cost conditions, with the objectives of reducing costs and improving the quality of care.

concurrent review: Ongoing review of treatment plans, typically for hospital patients. The review may include monitoring the patient's length of stay, scope of treatment, and plans for follow-up care after leaving the hospital.

exclusive provider organization (EPO): An arrangement similar to a preferred provider organization, but one that reimburses members only for services rendered by providers in its network. If an EPO member uses non-network providers, the member must pay the full cost of those services out of pocket.

fee-for-service: Payment is based on the specific service provided. It may be related to charges, costs, or a fee schedule.

health maintenance organization (HMO): A health plan that offers comprehensive health care from an established panel of providers to a voluntarily enrolled population on a prepaid basis. It combines the provision of health insurance with the provision of health care services.

group-model HMO: A health maintenance organization that contracts with a multispecialty medical group or groups to provide care to the HMO's membership. The medical group is managed independently of the HMO and is usually paid by the HMO on a capitated basis. The medical group, not the HMO, contracts with its physicians and may pay the physicians on a fee-for-service, salary, or other basis. Under a fully integrated group-model HMO, the medical group's practice is limited to the HMO's membership, with no fee-for-service patients. Fully integrated group-model HMOs should be distinguished from network-model HMOs, which contract with existing fee-for-service medical groups to serve the HMO's members along with the groups' fee-for-service patients. Under the network model, each medical group has a greater degree of autonomy from the HMO.

independent practice association (IPA): A health maintenance organization that contracts with individual fee-for-service physicians or groups to provide services to the HMO's members in the physicians' private offices. The physicians also continue to treat fee-for-service patients.

managed care: Any type of intervention in delivery and reimbursement of health care services that is intended to reduce unnecessary or inappropriate care and to reduce costs.

mixed-model HMO: A health maintenance organization that adopts one model initially, then expands by adding a component of a different model. For example, a staff-model HMO may expand its capacity by adding an IPA arrangement rather than by building new clinical facilities and hiring additional physicians.

network-model HMO: A health maintenance organization that contracts with two or more medical groups to serve the HMO's membership. The medical groups also continue to treat fee-for-service patients outside the HMO.

open-ended or open-access HMO: A health maintenance organization that allows members to use providers who do not participate in the HMO. When

using physicians outside the HMO, the HMO member is typically subject to conventional cost-sharing requirements.

preferred provider organization (PPO): An organization that contracts with an insurer or employer to arrange a network of providers whose services are offered to members of an insurance plan or employment group. Insured members typically are offered incentives--usually lower cost sharing--to use the PPO providers. The provider network is generally chosen on the basis of performance, and the PPO provides some type of utilization review. Many PPO providers agree to discount charges for PPO patients.

precertification or prior authorization: Requires that the patient or physician obtain advance approval for specific procedures and for nonemergency hospital admissions. Failure to obtain prior authorization may result in the insurer's paying less of the cost of the service or, in some instances, none of the costs.

retrospective review: Analyzes after the fact whether the treatment provided was necessary, appropriate, and covered by the plan. A negative review may result in nonpayment for the service or may simply serve to identify problem areas the insurer can address in the future.

staff-model HMO: A health maintenance organization that owns the clinical facilities its insured population uses and that employs physicians, typically on a salaried basis, who serve only the HMO's membership.

third-party administrators (TPAs): TPAs process claims for self-insured employers, usually charging fees reflecting their actual costs. Some TPAs may also arrange delivery systems and provide utilization review and management.

triple option plans: Packages that insurers offer to employers that include a health maintenance organization, a preferred provider organization, and a conventional fee-for-service plan.

utilization review organization: Organizations that contract with insurers and employers to assure patients of high-quality care in a cost-effective manner. They review the quality of medical services, analyze patterns of use in facilities, identify practice problems, and propose remedies. The protocol for review may include precertification, concurrent review, and retrospective review, more often for inpatient care than for outpatient services. Some organizations have begun to offer management support services, network development, and contract administration in addition to reviewing and monitoring services.

withholds, related to performance: Incentives to limit care to appropriate and cost-effective services. A portion of the payment due to providers may be withheld by the managed care organization and paid to the provider only if performance meets a certain standard.